

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JUL 11 1957

22423
STATE FILE NUMBER 5999

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST LOUIS,				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN ST LOUIS,	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DEPAUL HOSPITAL				Length of stay in 1b		d. STREET ADDRESS (If outside, give location) 4638 KOSSUTH AVE	
3. NAME OF DECEASED (Type or print) First LAURA Middle W. Last CLEARY				4. DATE OF DEATH Month JUNE Day 25 Year 1957			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOW <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAY 17, 1876	
9. AGE (In years last birthday) 81		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and state or country) ST LOUIS MISSOURI				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME UNKNOWN OSTER				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address JOHN CLEARY 4638 KOSSUTH AVE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Insufficiency DUE TO (b) Post Operative Shock DUE TO (c) Adeno Carcinoma Colon PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							INTERVAL BETWEEN ONSET AND DEATH 36 hrs. 36 hrs. unknown!
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 153x				
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from 1946 to 6-25-57 and last saw her alive on 6-25-57 Death occurred at 3:30 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE H.O. Schrepel, M.D. (Degree or title)				22b. ADDRESS 634 No. Grand St. Louis Mo		22c. DATE SIGNED 6-27-57	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE 6/28/57		23c. NAME OF CEMETERY OR CREMATORY MEMORIAL PARK CEMETERY		23d. LOCATION (City, town, or county) (State) ST LOUIS COUNTY MO	
24. FUNERAL DIRECTOR ADDRESS STROOT - CARROLL 4600 NATURAL BRIDGE				25. DATE RECD. BY LOCAL REG. JUN 27 '57		26. REGISTRAR'S SIGNATURE J. Carl Smith Mo mjb	

(Licensed Embalmer's Statement on Reverse Side)

*Dr. Schreier
9251058
Emo Theater Bldg
12 to 12th*

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....
M. W. Rueter

Licensed Embalmer No. 48

P. O. Address *St Louis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.